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In the Supreme Court of the United States.

OCTOBER TERM, 1982.

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2
AND
EAST JEFFERSON HOSPITAL BOARD,
PETITIONERS,

v.

EDWIN G. HYDE,
RESPONDENT.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT.

Brief of Amicus Curiae, the American Association of Nurse Anesthetists.

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Pursuant to Rule 36 of the rules of this Court, and with the consent of all parties,[1] the American Association of Nurse Anesthetists respectfully files this brief as *amicus curiae*.

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[1] Letters of consent have been filed with the clerk.

Interest of the American Association of Nurse Anesthetists.

The American Association of Nurse Anesthetists ("AANA") is a national professional organization, organized in 1931, which sets standards for the practice of nurse anesthetists and consists of approximately 23,000 certified registered nurse anesthetists ("CRNAs"). The AANA publishes standards which serve as general guides for the rendering of anesthesia care and interpretations explaining these standards.

Nurse anesthetists preceded anesthesiologists as administrators of anesthesia and, historically, nurses or nurse anesthetists have been the primary providers of anesthesia services to patients in hospitals. This practice is consistent with the traditional distinction of medical treatment: physicians provide the cure component and nurses provide the care component. Moreover, studies show that nurse anesthetists administer anesthesia with the same high rate of success as anesthesiologists. Today, more than 50% of anesthesia care is provided by nurse anesthetists.

The AANA has not been a party to this litigation. It is concerned, however, that the role and capabilities of nurse anesthetists have been incorrectly described in both the District Court and Court of Appeals decisions. These misconceptions resulted because the role of nurse anesthetists was incorrectly presented at the trial by the parties, a hospital and an anesthesiologist. Moreover, the witnesses at the trial did not include representatives of the nurse anesthetists. From the transcript of the trial court proceedings and the District and Appellate Court decisions, it is easily seen that the court was not familiar with the role that nurse anesthetists play in the administration of anesthetics.

The AANA has not adopted a position with regard to the propriety of exclusive contracts between hospitals and anes-

thesiologists. Nevertheless, since none of the parties to this litigation represent the interests of the AANA nor the 23,000 CRNAs who are its constituent members, the AANA feels obliged to set forth facts that have not heretofore been adequately presented in this action.

This brief is submitted to provide the Court with information regarding the historic and contemporary role of the nurse anesthetist as a fully qualified administrator of anesthesia. This viewpoint, omitted in the lower court proceedings, is essential for a complete understanding and a fair portrayal of the way in which the health care industry provides for the administration of anesthesia care.

Furthermore, because of the potentially different interests of CRNAs and anesthesiologists, the AANA requests that the Court limit its findings and decision in this case to anesthesiologists, recognizing that circumstances regarding nurse anesthetists, which are not properly before the Court, may be different.

Summary of the Argument.

The AANA calls the Court's attention to a number of facts relating to the historic and contemporary role of nurse anesthetists which have been omitted or incorrectly presented in the lower courts.

In particular, the Court should be aware that nurse anesthetists have been administering anesthesia for more than a century. In addition, more than half of anesthesia services in the United States are administered by nurse anesthetists and studies show that they do so with the same high degree of quality as anesthesiologists.

The AANA was not a party to this litigation and did not participate either in the trial or appeal to the Fifth Circuit Court

of Appeals. While it takes no position as to the merits of the action, it urges the Court to strictly limit its decision to the specific issues raised by the parties to this litigation. The Court should be particularly cognizant that the issues in this matter relate to staff privileges for anesthesiologists, and issues relating to nurse anesthetists, *who are not before the Court*, may be entirely different.

Argument.

I. Historically, Nurse Anesthetists Preceded Anesthesiologists as Administrators of Anesthesia.

In its *amicus* brief before the Fifth Circuit Court of Appeals, the American Society of Anesthesiologists noted that "the emergence of anesthesiology as a distinct medical specialty has been a comparatively recent development. . . ." (Brief of *Amicus Curiae* of the American Society of Anesthesiologists at 3.) In fact, nurses were the first group from which members were consistently trained as anesthetists (I. Gunn, "Nurse Anesthetist — Anesthesiologist Relationships: Past, Present, and Implications for the Future," 43 AANA Journal No. 2, April 1975 at 131). Thus, it was nurse anesthetists who preceded anesthesiologists.

The development of a physician specialty devoted to anesthesiology is quite recent. The American Society of Anesthesiologists was not formed until 1937. At that time, there were only ten anesthesiology residency programs in the entire United States (Adriani, 51 Anesthesia and Analgesia No. 5, September/October, 1972). By 1940, there were only 1,000 members of the American Society of Anesthesiologists (Hingson, 46 Anesthesia and Analgesia No. 1, January/February

1967). On the other hand, nurses were administering anesthetics long before the turn of the century. A professional organization of nurse anesthetists was formed in 1931 and in 1952, it became the accrediting agency of the United States Office of Education for programs and schools of nursing anesthesia (I. Gunn, *supra*). In contrast, prior to 1968, a physician was classified as an "anesthesiologist" merely by self-designation (F. Orkin, M.D., Studies of Anesthesia Manpower, *Health Care Delivery in Anesthesia* (1980) at 123).

Courts have long supported the administration of anesthesia by nurses. In *Frank* v. *South*, 175 Ky. 416, 194 S.W. 375 (App. Ct. Ky. 1917), the court ruled that a nurse giving anesthesia is not engaged in the practice of medicine within the meaning of the statute. The court in *Chalmers-Francis* v. *Nelson*, 6 Cal.2d 402, 57 P.2d 1312 (1936), held that a nurse delivering an anesthetic under a surgeon's direction during surgery is not "diagnosing or prescribing" within the meaning of the California Medical Practice Act. Similarly, in *State* v. *Borah*, 51 Ariz. 318, 76 P.2d 757 (1938), the court held that registered nurses may administer anesthetics under the direction of, and in the immediate presence of, a licensed dental surgeon.

Thus, a brief review of the history of anesthesiology demonstrates the long-standing tradition of the administration of anesthesia by nurse anesthetists and the recent development of physicians specializing in the field of anesthesiology.

The history of the role of nurse anesthetists in delivering anesthetics is also consistent with the traditional distinction between medicine and nursing. The traditional philosophy of medicine has been that physicians provide the cure component of the treatment and that nurses provide the care component. Cure is often characterized by the functions of diagnosis and its treatment. Anesthesia, except for a minimal number of diagnostic or therapeutic aspects, is not perceived as *primarily* diagnostic or therapeutic. Thus, it does not fit well into the

cure model even though at times it gives occasion for diagnosis and treatment.

> Anesthesia is basically a process through which patients are rendered insensitive to pain, with or without unconsciousness, and often temporarily paralyzed to facilitate other medical requirements. As a result of the process, the patient is rendered incapable of caring for himself. Thus, the care component becomes critical to the process, mandating vigilance in monitoring aimed at protecting and detecting changes requiring modification of the process to maintain the patient at near optimal status. This is and has been a traditional nursing function. (I. Gunn, Professional Territoriality and the Anesthesia Experience, *Nursing Issues and Nursing Strategies for the 80's*, publication in May, 1983.)

II. Certified Registered Nurse Anesthetists (CRNAs) are Highly Educated and Must Continuously Demonstrate their Ability and Education in Bi-Annual Recertification Programs.

The basic curriculum of an accredited nurse anesthesia educational program in the United States requires twenty-four months of study and is offered at baccalaureate and masters degree levels or as a certificate-granting program. Licensed professional nurses entering these programs must have a minimum of one year of nursing experience in an acute care setting. However, the typical applicant has at least two years of nursing experience in an intensive care unit.

Upon graduation from a nurse anesthesia educational program, accredited by the Council on Accreditation of Nurse

Anesthesia Educational Programs/Schools, an autonomous body composed of anesthesiologists, nurse anesthetists and representatives of the public, a licensed professional nurse is eligible to become a CRNA. In order to obtain certification, the applicant must successfully write a national examination administered by another autonomous body, the Council on Certification of Nurse Anesthetists. *See, Anesthesia and the Law*, edited by Peters, Fineberg, Kroll and Collins (1983).

A CRNA must also maintain certification through a recertification process administered by the Council on Recertification of Nurse Anesthetists of the AANA. This process requires that every two years each CRNA demonstrate evidence of: (1) current licensure as a registered nurse; (2) active practice as a nurse anesthetist; and (3) appropriate continuing education within the speciality. *Anesthesia and the Law, supra.*

III. Nurse Anesthetists Administer Anesthesia with the Same High Level of Results as Anesthesiologists.

As noted above, anesthesia services are sometimes provided by nurse anesthetists and sometimes by anesthesiologists. Studies of mortality rates related to the use of anesthesia have indicated that there is no significant difference in the quality of care delivered by anesthesiologists and nurse anesthetists. *See,* W. Forrest, Outcome — The Effect of the Provider, *Health Care Delivery in Anesthesia* (1980), at 141: "Thus, using conservative statistical methods, we conclude that there were no significant differences in outcomes between the two groups of hospitals defined by type of anesthesia provider" (referring to hospitals in which anesthesiologists primarily were the providers and hospitals where nurse anesthetists were primarily the providers); A. Bechtoldt, "Committee on Anesthesia Study, Anesthesia Related Deaths, 1969-1976," 42 N.C. Med. J. No. 4, April 1981 at 257: "Therefore, when we calculated the in-

cidence of anesthetic related deaths for each group which administered the anesthetic . . . we found that the incidence among the three major groups (the CRNA, the anesthesiologists, and the combination of CRNA and anesthesiologists) to be rather similar." *See also, Health Care Delivery in Anesthesia,* edited by Hirsch, Forrest, Orkin and Wollman (1980) at 220: "It was surprising that the stage of training of the anesthesiologist or administration of an anesthetic by a nurse anesthetist or anesthesiologist seemed to affect risk very little. . . ."

In short, these studies show that, contrary to the impression given to the trial court judge, there is no difference in outcome whether the provider is a nurse anesthetist or an anesthesiologist. The studies reflect no difference in patient care or mortality rates. Implications in the trial transcript and lower court decisions that nurse anesthetists provide lower standards of health care are factually incorrect and misleading (W. Forrest, *supra*; A. Bechtoldt, *supra*).

IV. Nurse Anesthetists Practice in Every State and Provide More than 50% of Anesthesia Services in the United States.

The field of anesthesiology in today's hospitals is composed of both anesthesiologists and nurse anesthetists. More than 50% of anesthesia services are provided by nurse anesthetists who practice in collaboration with, or under the direction of, physicians, dentists, and other health professionals. In rural areas where there are fewer anesthesiologists, nurse anesthetists provide more than 70% of the anesthesia care. (AANA Summary to Accompany "Certified Registered Nurse Anesthetist (CRNA) Reinbursement Legislation.")

Not only does every state in the country recognize the role of nurse anesthetists and authorize them to provide anesthesia services, thirty-four states identify nurse anesthetists as ad-

vanced or expanded-role professional nurses. In short, the administration of anesthesia by nurse anesthetists is a widespread and acceptable practice in the health profession.

While most anesthesiologists are either self-employed or work in group practices, the same is not true of CRNAs. Indeed, almost 60% of CRNAs are employed within hospitals while 30% are employed by physicians, 5% are employed by the military, veterans and public health hospitals and only 5% are self-employed. The median annual earnings of CRNAs is approximately $27,750 as compared to anesthesiologists, whose median is $110,000 (as reported by the Health Care Financing Administration). AANA Summary, *supra*.

Twenty-four Blue Cross/Blue Shield plans (representing over 30% of all Blue Cross/Blue Shield plans) directly reimburse CRNAs. Eight states permit reimbursement of CRNAs directly through Medicaid programs. Of the private insurance plans surveyed by AANA, 57% indicate that they can provide direct reimbursement to CRNAs for anesthesia services. AANA Summary, *supra*.

V. The Lack of Participation by Nurse Anesthetists in the Trial is Reflected in Misunderstandings Concerning the Role of the Nurse Anesthetist Which are Reflected in the Transcript of the Trial Court Proceedings, and in the District and Appellate Court Decisions.

It is a basic tenet of our legal system that a party will not be bound by a court proceeding unless the party has had the opportunity to be represented at the proceeding. The instant action presents this Court with a dispute between a hospital and an anesthesiologist seeking admission to practice at the hospital. Testimony at the trial was provided by hospital administrators, anesthesiologists and expert witnesses, but no repre-

sentatives of nurse anesthetists participated. The reason for this is obvious. The dispute was between a hospital and an anesthesiologist and did not directly concern nurse anesthetists.

Nevertheless, during the course of the trial, there was a significant amount of testimony regarding the role of nurse anesthetists and how their professional function interrelates with the services provided by anesthesiologists. Unfortunately, much of this testimony was misleading or incorrect and was provided either by persons without expert knowledge or by persons who had an adverse position to advocate. The trial court apparently took the erroneous view that anesthesiologists could speak for everyone providing anesthesia services while the facts do not support this conclusion. Moreover, there was no representative of nurse anesthetists at the trial to challenge the assertions made by the various witnesses.

The resulting opinions of the District and Appellate Courts have also incorporated the incorrect assertions about the role and history of nurse anesthetists. The purpose of this brief, therefore, is to call this Court's attention to some of the incorrect or misleading material contained in these lower court papers so that it will not be perpetuated in the opinion which is to be rendered by the Court in this matter.

A. *Proceedings in the District Court.*

The trial court acted upon several fundamental misconceptions about CRNAs, both during the trial of this action and in its decision. Some of the more egregious examples of those misconceptions, as well as certain biased, inaccurate or misleading testimony about CRNAs, are set forth herein.

Judge Mitchell quite apparently viewed the use of CRNAs as being tantamount to fraud. He termed the hospital's practice of providing services by CRNAs under anesthesiologist super-

vision, while billing as if an anesthesiologist had performed the procedure, as a "shoddy practice" (Tr. Vol. IA at 52)[1] and a "ripoff" of the patient (Tr. Vol. IA at 54). Had Judge Mitchell's statements been limited to the financial aspect of this arrangement, the AANA would perhaps not take exception to it, but further reading of the record reveals the actual basis for the court's perception.

The following colloquy between Judge Mitchell and Mose Ellis, the administrator of East Jefferson General Hospital, is illustrative:

> THE WITNESS: . . . if ever anesthesia were given by M.D. anesthesiologists . . . compared to the present system. . ., costs would surely go up higher than right now.
> THE COURT: The standard of medical care would go up, too.
> THE WITNESS: I think the standard of medical care would go up, but we are talking about costs now. . . .
> THE COURT: Surely from a medical standpoint, isn't that the ideal situation? Wouldn't you prefer having an M.D. anesthesiologist administer an anesthetic rather than a nurse?
> THE WITNESS: I know me, I would.
> THE COURT: I have had several operations and I understood that an M.D. anesthesiologist attended me. Now I know. Now I know that that was not so.

(Tr. Vol. IA at 64-66.)

Thus, Mr. Ellis, who was neither a medical doctor nor had any medical training or responsibilities (Tr. Vol. IA at 4) and who was not qualified as a witness as to standards of anesthesia

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[1] Citations in this form are to the transcript of the District Court proceedings as no joint appendix was available to the amicus.

practice, was permitted, and in fact encouraged, to assert his private opinions and his preference for M.D. anesthesia over nurse anesthesia. Mr. Ellis also testified to his opinion that a complete substitution of CRNAs for M.D. anesthesiologists would result in a reduction of patient care (Tr. Vol. IA at 57-58). Such opinion testimony was repeatedly accepted as fact by the trial judge, who continued to express his private preference for M.D. anesthesia.

The judge went on to state: "I'll tell you one thing, if I have to have another operation, I'm going to get me a guard to stand there and guard the anesthesiologist and not let him out of the room because I'm tired of you ripping off the citizens." (Tr. Vol. IB at 11.)

Mr. Ellis was aware that there was an alternative view, but in the absence of participation by CRNAs, this material was not further explored. Mr. Ellis testified that:

> However, I will tell you that our surgeons have been questioned over and over and over again for nine years about the quality of the service, and because — especially every time we have been talking about a new contract. We get a unanimous feeling from them that they are very happy with the quality of service and every one of their cases they shift essentially, the anesthesia is given by the nurse anesthetists.

(Tr. Vol. IA at 70.)

The depth of the trial court's misperception of the facts is graphically illustrated by the following discussion between the judge and Mr. Ellis:

> THE COURT: Why don't we just do away with physician anesthesiologists and say, all right, just nurses do it from now on?

THE WITNESS: That would be a reduction in quality of care.

THE COURT: You would kill a lot of people, wouldn't you?

THE WITNESS: It would be a reduction in quality.

THE COURT: That's for sure.

(Tr. Vol. 1A at 50.)

In his zeal to denigrate a proud and competent profession, the judge states, totally without basis, that care by well-educated, dedicated and experienced professionals will lead to needless patient fatalities. This profession deserves far better treatment than it has received. Indeed, had the trial court's obvious bias not foreclosed further inquiry, it would have been apparent, as the studies cited in this brief make clear, (*supra* Argument III at 7-8) that mortality rates and the quality of care are not affected by the identity of the anesthesia provider.

Later in Mr. Ellis' testimony, both counsel for the plaintiff and the court demanded to know: "who set the standard of allowing nurses to give anesthesia?" (Tr. Vol. IA at 75.)

The actual historical development of nurse anesthesia (and the fact that anesthesiologists are relative late-comers to the profession) was never really explained to the court, although evidence of that development and the professional standing of CRNAs was known and readily available to the parties through authoritative sources such as those cited in this brief.

Neither was the court informed of the demanding education, licensure and certification procedures which the modern CRNA has undergone. Rather, the court was permitted to continue in its mistaken belief that nurse anesthetists represent a pragmatic and somewhat second-best interim solution to an alleged shortage of anesthesiologists.

The respective professional competence of anesthesiologists and of CRNAs was not, or should not have been, at issue in this case. As the studies cited above indicate, CRNAs can and do practice with the same high level of care as anesthesiologists (W. Forrest, *supra*; A. Bechtoldt, *supra*; F. Orkin, *supra*). Yet this issue, and Judge Mitchell's emotional reaction to it, was permitted by the court and by counsel to dominate the proceedings.

The opinion testimony of the one expert witness called during the trial of this action, an anesthesiologist, was unsupported and self-serving. Dr. John Adriani testified that his long-term intention in setting up a residence program for anesthesiologists at Charity Hospital in New Orleans was "the idea of one day eliminating the CRNAs." (Tr. Vol. II at 45.)

Notwithstanding that the issue of whether nurse anesthetists practice medicine had been decided by the courts sixty years before and that CRNAs practiced in all fifty states, the trial judge and Dr. Adriani engaged in the following colloquy:

> THE COURT: Don't some states require that the anesthesiologist be a medical doctor?
> THE WITNESS: Yes. Anesthesiology is considered the practice of medicine.
> THE COURT: That's right.
> THE WITNESS: A nurse can't practice medicine.
> THE COURT: It looks to me like they're delegating the field of anesthesiology by turning it over to the nurse.
> THE WITNESS: They have. That's exactly the point that I'm trying to make.

(Tr. Vol. II at 36.)

B. *The District and Appeals Court Decisions.*

The opinions in the lower courts in this matter have also incorporated some of the erroneous and misleading testimony which was adduced at trial. This testimony is particularly offensive where it reflects poorly on the quality of care provided by nurse anesthetists, especially since the CRNAs did not have the opportunity to present evidence to the court or cross-examine the witnesses. Some of the more obvious examples follow.

Dr. Charles Eckert, an anesthesiologist employed by the group of anesthesiologists contracted to practice at East Jefferson General Hospital, testified at the trial. The District Court referred to his testimony in its opinion as follows:

> Eckert testified that there are one hundred fifty-six anesthesiologists in Louisiana and three hundred forty-five hospitals with operating rooms. He testified that in order to have an anesthesiologist present at every operation, East Jefferson would have to employ more than twelve anesthesiologists on its staff.

Hyde v. *Jefferson Parish Hospital District No. 2*, 513 F. Supp. 532, 538 (E.D. La. 1981).

This statement implies that it is desirable to have an anesthesiologist, as opposed to a nurse anesthetist, present at every operation. The trial court gave the impression that the only reason this could not be accomplished was a shortage of anesthesiologists.

This implication is based on a faulty premise. It fails to acknowledge the fundamental role of the nurse anesthetists. In particular, it overlooks the fact that nurse anesthetists did not evolve as a result of a shortage of anesthesiologists. Rather, they were administering anesthesia many years prior to the emergence of anesthesiologists. To suggest otherwise denigrates the important functions historically performed by nurse anesthetists.

Some of the above testimony presented to the trial court was also adopted by the Fifth Circuit Court of Appeals and incorporated into its opinion. One of the most obviously misleading impressions adopted by the Appeals Court is reflected in the following excerpt from its opinion: "Another twist which is important to an understanding of the specialty is that more than in any other medical specialty, anesthesiologists have been confronted with the growth of a paraprofessional counterpart — the anesthetist." *Hyde* v. *Jefferson Parish Hospital District No. 2*, 686 F.2d 286, 291 (5th Cir. 1982.)

The trend noted by the court is presented in precisely the reverse order. Anesthesiologists emerged in a field dominated by nurse anesthetists and have thereby developed their specialty in an area which was historically a non-physician domain.

An even more offensive misstatement of facts is incorporated in a later portion of the opinion of the Appeals Court.

> Quality is lowered by this restraint while at the same time the hospital's profit, as demonstrated above, is raised. In the instant case, there was also testimony that the profit motive caused the hospital to hire nurse anesthetists in place of needed anesthesiologists, a practice which dilutes the professional coverage available.

686 F.2d at 292.

First, there is absolutely no evidence that "quality is lowered" when anesthesia is administered by nurse anesthetists rather than by anesthesiologists. The court assumes that a longer-educated individual can perform a function better because of his or her longer education. This assumption is not necessarily true. In the case of administering anesthesia, it is simply not true at all. The studies cited above clearly demonstrate that the quality of care is of the same high standard

when anesthesia is administered by nurse anesthetists rather than anesthesiologists.

Second, hospitals do not hire nurse anesthetists "in place of needed anesthesiologists." Hospitals employ nurse anesthetists because they are well educated and effective in administering high quality anesthesia care.

Conclusion.

The AANA does not take a position on the merits of this action. Moreover, the AANA believes that the foregoing factual issues are not necessarily relevant to the legal issues to be decided in this matter. Nor does the AANA take the position that the foregoing errors of fact lead to an erroneous legal conclusion. However, the AANA submits to this Court that the lower court proceedings and opinions erroneously portray the role of the nurse anesthetist and detract from the professional reputation established by nurse anesthetists throughout the country over many years.

The AANA respectfully submits to this Court that the foregoing represents merely a brief examination of the conflicting and collaborative roles of anesthesiologists and nurse anesthetists. The trial court and the Circuit Court of Appeals rendered opinions and conclusions regarding these roles without the opportunity to consider testimony from the nurse anesthetists. Therefore, both courts reached a number of erroneous conclusions. The AANA urges this Court to review the facts outlined herein so that it will not repeat the factual errors of the lower courts.

Further, the AANA requests that this Court strictly limit its decision to the parties and the issues raised at the trial. In particular, this Court should be cognizant that the circumstances

of this action relate to anesthesiologists. Issues relating to nurse anesthetists, who are not before this Court, may be entirely different. This Court must recognize that the factual issues are complex; that the evidence in the record relating to the field of anesthesia was not complete; and that the impact on the health care industry of any decision of this Court without sufficient facts may produce unintended results. Therefore, we urge this Court to limit its decision so as not to impact upon areas of the health care field not represented in the trial court proceedings.

Finally, this Court should not assume that the delivery of quality anesthesia care is dependent on whether the provider is an anesthesiologist or a nurse anesthetist. The studies produced by qualified professionals clearly demonstrate that the identity of the anesthesia provider does not effect the quality of the service provided.

Respectfully submitted,

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